TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Joseph Moza, M.D.

Respondent Name
TASB Risk Management Fund

MFDR Tracking Number
M4-15-4020-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
August 12, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… this request was in response to a $300.00 reduction of the $1800.00 for the DDE performed on 1-31-15."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "… Maximum Medical Improvement (MMI) evaluation reimbursed at $350 … Impairment Rating (IR) (range of motion of the lower extremity (paid at $300) range of motion of the spine (reimbursed at $300.00 incorrectly) … It is unclear as to what the provider is billing the five units and $300.00 for specifically. There is no documentation that specifically outlines the reason for this request."

Response Submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 31, 2015	Designated Doctor Examination	$300.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the guidelines for billing and reimbursing Division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - W3 – Additional payment made on appeal/reconsideration.

Issues

1. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. While charges for multiple impairments and an examination to determine the extent of the compensable injury were included on the Medical Fee Dispute Resolution Request (DWC060), the requestor is seeking $0.00 for these charges. Therefore, these charges will not be considered.

   Per 28 Texas Administrative Code §134.204 (j)(3), "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation indicates that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the correct MAR for this examination is $350.00.

   Per 28 Texas Administrative Code §134.204 (j)(4), "The following applies for billing and reimbursement of an IR evaluation. (C) … (ii) The MAR for musculoskeletal body areas shall be as follows... (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area. (-b-) $150 for each additional musculoskeletal body area." The submitted documentation indicates that the requestor provided an impairment rating and performed a full physical evaluation with range of motion for the left lower extremity and the lumbar spine. Documentation does not support that impairment ratings were provided for other body areas. Therefore, the correct MAR for this examination is $450.00.

2. The total MAR for the disputed services is $800.00. The insurance carrier paid $950.00 No further reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	September 30, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.